Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $522.00 for date of service, 04/18/01.
   b. The request was received on 03/06/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. UB-92
   c. EOBs
   d. Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 06/11/02. The fax confirmation sheet is included in the case file. There is no response from the Requestor in the file. A "No Additional Information Received" from the Requestor is reflected in Exhibit I.
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   There is not a carrier sign sheet submitted with the dispute packet. There is no carrier initial response in the case file regarding the dispute dated 03/06/02. Furthermore, the Commission notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 06/11/02. There is no Carrier 14 day response to this medical fee dispute in the file.

III. PARTIES' POSITIONS

1. Requestor: No position statement.

2. Respondent: No position statement.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 04/18/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $1,115.00.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $348.28.

5. Per the Requestor's Table of Disputed Services, the amount in dispute is $522.00.

6. Per the Requestor's Table of Disputed Services, the CPT codes in dispute for date of service are 76499-27-22, 76499-27, and A4209.

V. RATIONALE

Medical Review Division's rationale:

The carrier denied the charges in dispute for CPT codes 76499-27-22 and 76499-27 as "F – CODE - P – N – THE MEDICAL FEE GUIDELINE STATES IN THE IMPORTANCE OF PROPER CODING 'ACCURATE CODING OF SERVICES RENDERED IS ESSENTIAL FOR PROPER REIMBURSEMENT'. THE SERVICES PRBFORMED [sic] ARE NOT REIMBURSABLE AS BILLED." There is no EOB for CPT code A4209. The Medical Review Division's decision is rendered based on denial codes submitted to the Provider prior to the date of this dispute being filed.

The provider failed to submit the Table of Disputed Services per Rule 133.307 (e) (1) (C). The "Totals" column does not coincide with the figures reported in the "Disputed Services" columns.

When determining whether or not additional reimbursement is warranted, the Medical Review Division must first determine that the services were rendered as billed. After review of the dispute file, no documentation was noted to support the services billed. **No** reimbursement is recommended.

The above Findings and Decision are hereby issued this 20th day of August 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.